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IN THE
Supreme Court of the United States
OCTOBER TERM, 1993

UNITED WIRE, METAL & MACHINE HEALTH AND WELFARE FUND; TRUSTEES OF THE OPERATING ENGINEERS LOCAL 825 WELFARE FUND; TEAMSTERS LOCAL 11 BENEFIT PLAN; LOCAL 807 LABOR-MANAGEMENT HEALTH FUND; THE TRUSTEES OF THE LOCAL 807 LABOR-MANAGEMENT HEALTH FUND; LOCAL 464A UNITED FOOD AND COMMERCIAL WORKERS UNION GROUP REIMBURSEMENT WELFARE FUND; and LOCAL 945 IBT WELFARE FUND,

Petitioners,

v.

MORRISTOWN MEMORIAL HOSPITAL; FRANCES J. DUNSTON, in her capacity as New Jersey Commissioner of Health; *et al.*,

Respondents.

On Petition for a Writ of Certiorari to the United States Court of Appeals for the Third Circuit

BRIEF OF THE NATIONAL COORDINATING COMMITTEE FOR MULTIEMPLOYER PLANS AS AMICUS CURIAE IN SUPPORT OF PETITIONERS

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INTRODUCTION

The National Coordinating Committee for Multiemployer Plans ("NCCMP") urges this Court to review the decision below. By effectively creating a judicial exemption from ERISA preemption for state health care financing statutes—without regard to their impact on employee benefit plans—on the grounds that these laws fall within traditional state police powers, the Third Circuit's

ruling threatens to disproportionately burden self-funded multiemployer health benefit plans and therefore to undermine the ability of these plans to continue to provide benefits to their participants and beneficiaries.

The decision below is inconsistent with the plain language of ERISA's preemption provision as well as with every decision of this Court which has interpreted the scope of ERISA preemption. Instead, the Third Circuit fashioned an expanded "cost of doing business standard" to determine whether a state law—despite its inordinate impact on self-funded ERISA plans—should nevertheless survive ERISA preemption because the state law promotes a social objective that the state wishes to encourage and to regulate under its police powers. The decision below therefore transcends its subject matter; *i.e.*, whether New Jersey's hospital rate-setting statute is preempted and pierces the very heart of what Congress intended to achieve through ERISA preemption; namely, the insulation of self-funded employee benefit plans from all state regulations that affect the administration, structure, or solvency of such plans, except for those specific matters which Congress—in the exercise of its legislative powers—expressly exempted.

INTEREST OF THE NATIONAL COORDINATING COMMITTEE FOR MULTIEMPLOYER PLANS

The NCCMP is a nonprofit, tax-exempt organization that was formed after the enactment of ERISA to participate in the further development of employee benefits legislation, government regulations promulgated to implement ERISA, and other laws affecting multiemployer plans. Currently, more than 190 multiemployer plans and related international unions, located in at least 37 states, are affiliated with the NCCMP. These plans are representative of all of the union's multiemployer plans, which cover more than nine million workers. The decision below has far-reaching adverse consequences for all multiemployer plans and, therefore, is particularly adverse to

the interests of NCCMP affiliates, which represent the majority of participants in such plans.

Because of the broad range of the NCCMP's constituent organizations and its contacts with hundreds of trustees charged with the administration of multiemployer plans in accordance with ERISA's fiduciary duty rules and principles, the NCCMP believes that it is qualified to advise the Court of the practical implications of the decision below for multiemployer plans and to state the position of the trustees, participants, and beneficiaries of such plans. The NCCMP has participated as an *amicus curiae* in numerous cases involving important issues affecting multiemployer plans. *See, e.g., Local 144 Nursing Home Pension Fund, et al. v. Demisay,* —— U.S. ——; 113 S. Ct. 2252 (1993); *Concrete Pipe & Products of California v. Construction Laborers Pension Fund for Southern California,* —— U.S. ——, 113 S. Ct. 2264 (1993); *FMC Corp. v. Holliday,* 498 U.S. 52 (1990). The NCCMP respectfully submits this brief as *amicus curiae* in support of Petitioners pursuant to Rule 37.2. Written consents from all parties have been filed with the Clerk of the Court.

SUMMARY OF REASONS FOR REVIEW

In ruling that the DRG surcharges do not "relate to" employee benefit plans in such a way as to trigger preemption, the court below impermissibly carved out a judicial exemption from ERISA preemption for state health care financing statutes on the erroneous assumption that Congress did not intend to frustrate the efforts of states to regulate health care costs through their police powers.

The issue is one of great national importance because there are many states which already have or are developing programs to subsidize the uninsured and uninsurable by imposing taxes, premiums, or surcharges on plan participants. To the extent such premiums are payable by ERISA plans, and are not related to the benefits received by the participants, these payments constitute a prohibited

diversion of plan assets to fund the benefits of persons other than participants and beneficiaries. Such cost-shifting violates the fundamental premise of ERISA, that plan assets must inure *exclusively* to the benefit of its participants and beneficiaries. 29 U.S.C. § 1104(a)(1)(A).

Notwithstanding a clear conflict with express prohibitions in ERISA, the court validated the DRG surcharges by mischaracterizing them as a mere cost of doing business in the state. The court thereby disregarded the nature of collectively bargained multiemployer plans and the manner in which such plans are founded and funded, while also intruding upon an area reserved exclusively to the legislative powers of Congress.

The language of ERISA § 514 does not tolerate judicial exemptions for state laws relating to ERISA plans, even if those laws serve useful social purposes. Rather, § 514(a) supersedes *all* state laws relating to employee benefit plans other than those which Congress expressly exempted. Congress knew how to draft an express exemption for state health care financing statutes and did so for Hawaii's Prepaid Health Care Act, 29 U.S.C. § 1144(b)(5)(A). More recently, legislative efforts have been made—to date unsuccessfully—to enact additional exemptions for other state health care financing laws, including DRG statutes similar to New Jersey's.

The NCCMP seeks review because of its fundamental belief that the health care crisis must be resolved by national health care reform, not by piecemeal state legislation which, if enforced by federal courts, could cripple multiemployer plans. The NCCMP also seeks review because it is concerned that the economic impact of other socially useful state laws will no longer figure in the preemption calculus on the assumption that such economic burdens are a mere cost of a plan's doing business in the state. Finally, the NCCMP seeks review because the Third Circuit's ruling clouds the clear standards of preemption that have been enunciated by this Court and therefore, undermines the ability of plans to govern themselves in accordance with this Court's guidelines.

REASONS FOR REVIEW

THE DECISION BELOW RAISES ISSUES OF GREAT NATIONAL IMPORTANCE WITH REGARD TO THE SCOPE OF ERISA PREEMPTION, DISPROPORTIONATELY BURDENS SELF-FUNDED MULTIEMPLOYER HEALTH BENEFIT PLANS, AND IS INCONSISTENT WITH THIS COURT'S PREVIOUS DECISIONS.

I. THE DECISION BELOW EFFECTIVELY CREATES A JUDICIAL EXEMPTION FROM ERISA PREEMPTION FOR STATE HEALTH CARE FINANCING STATUTES WITHOUT REGARD TO THE IMPACT OF THOSE STATUTES ON SELF-FUNDED MULTIEMPLOYER PLANS.

It is now well established that ERISA was enacted to promote the financial stability of employee benefit plans and to assure that their participants receive the benefits upon which they rely. *Nachman Corp. v. PBGC*, 446 U.S. 359 (1980).

It is equally well established that the costs of providing health care have escalated out of all proportion,[1] and are threatening either to destroy private welfare plans or to force those plans to take drastic measures to remain solvent, including restricting or eliminating a whole range of benefits and terminating coverage for retirees.

The New Jersey statute[2] that is the subject matter of the present petition for review was designed to contain the

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[1] *See Clinton Administration Description of President's Health Care Reform Plan, American Health Security Act of 1993, dated September 7, 1993*, BNA Special Supplement (September 13, 1993). According to this Report, health care costs are rising faster than other sectors of the economy; will consume about two-thirds of the increase in the Gross Domestic Product ("GDP") for each American for the rest of the decade; and will grow from 14% of the GDP to 19% without regard to an expansion of coverage to insure all Americans. (S-3.)

[2] New Jersey Health Care Facilities Planning Act, as amended and supplemented by the Health Care Cost Reduction Act, N.J.S.A. 26:2H-1 *et seq.*, and regulations promulgated thereunder, N.J.A.C. 8: 31B *et seq.* The statute will be referred to henceforth as the "DRG statute." The DRG statute was amended, effective January 1,

costs of health care within the state and to assure the financial solvency of New Jersey hospitals, which are prohibited by law from denying admission to any patient based on the ability to pay.

However, to achieve this end, in substantial part, the New Jersey law imposed three separate surcharges on each patient's hospital bill, which were payable by ERISA plans although the charges had no relation to the services provided or benefits received by the plan's participants and beneficiaries; *e.g.*, a 19.1 percent surcharge to reimburse the hospital for the costs of providing uncompensated care (including bad debts); a 7 percent surcharge to reimburse the hospital for the difference between federal Medicare payments for specific services provided and the DRG rates established for those services (payable by non-Medicare recipients); and a maximum 11 percent surcharge to reimburse the hospital for discounts permitted to certain high volume insurers such as Blue Cross and Blue Shield and to plans having open enrollment. Thus, in addition to the base DRG rates, which were designed both to contain the cost of medical care while compensating hospitals for the direct and indirect costs associated with providing specific services, and which in many cases far exceeded the actual itemized cost of benefits received by plan participants,[3] the three surcharges required ERISA

1993, to deregulate rates. However, the amendments do not render the issues moot. See footnote 5, *infra*.

[3] For example, according to testimony given by the Fund Administrator of the Steamfitters Welfare Fund, Local 475, at a Public Hearing before the Assembly Corrections, Health and Human Services Committee on DRG Hospital Reimbursement System and State Waiver for Medicare (December 20, 1984), the basic DRG rate for claims submitted to the Fund often exceeded actual itemized costs by 100%-500%. In a recent letter to the NCCMP, the same Fund Administrator has advised that the Fund's escrow account currently contains the sum of $462,405.62 for DRG claims in excess of itemized costs as compared with $40,000 for claims in which actual costs were more than the assigned DRG. As pointed out by Petitioners, one feature of the DRG statute that was particularly adverse to self-funded plans was the limited inability to appeal excessive and inequitable DRG rates.

plans to pay additional charges of up to 37 percent of the base DRG rate to reimburse New Jersey hospitals for the cost of providing treatment to persons who were not participants or beneficiaries of the plans.

The financial impact of a 37 percent increase on charges payable by ERISA plans is staggering. As Judge Nygaard pointed out in his dissenting opinion:

> The surcharges are paid not by the general public at large, but by the less than 25 percent of the population who use hospital services. Of those 25 percent, about 75 percent receive the uncompensated care assessments challenged here. ERISA plan participants comprise only about 15 percent of the hospital patients, but pay about 40 percent of the more than $1.1 billion shortfall generated by the state-mandated cost shifts.

(App. 37a).[4]

One NCCMP affiliate, the Hotel Employees and Restaurant Employees International Union Welfare Fund, recently advised that it has placed the disputed portion of each patient's bill into an escrow account.[5] Checks paid into the escrow account in 1992 and the first few months

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[4] References to the court of appeal's decision will refer to the Appendix to the Petition for Certiorari filed by the NYSA-ILA Welfare Fund in No. 93-115.

[5] As noted in the petition of the Carpenters Welfare Fund (No. 93-193, p. 12), some plans, during the pendency of this litigation, have paid the DRG surcharges under protest, while others have placed the amounts into escrow, reserving the right to assert claims for reimbursement in the event the DRG surcharges are held to be preempted. For this reason alone, the court of appeals has conceded that the plans' claims are not moot, although New Jersey amended the DRG statute, effective January 1, 1993, to eliminate the DRG system of rate-setting in favor of deregulated market competition. L. 1992, c 160, N.J.S.A. § 26:2H-18.51 *et seq.* Under the new law, New Jersey hospitals will still be prohibited from denying access to treatment on the basis of an individual's ability to pay. However, hospitals will be free to set their own rates and will receive reimbursement from a new Health Care Subsidy Fund which, for the next three years will be financed in substantial part by revenues from employers and employees.

of 1993 alone total $1,172,096.14. The Fund paid an additional $533,503.25 under protest.

Notwithstanding the enormous impact on self-funded multiemployer plans, the court of appeals opined that

> [T]his effect is no different in kind . . . from any state regulation that increases the cost of goods or services that hospitals consume and pass on in hospital costs, *i.e.*, utility costs, the wages of its employees, waste disposal costs, etc. (App. at 26a.)

Therefore, the court concluded that the DRG statute was "a generally applicable law" that was not intended to regulate the affairs of ERISA plans; did not single out such plans for special treatment; was not predicated on the existence of ERISA plans; had no effect on the structure or administration of ERISA plans; and, in sum, did not "relate to" ERISA plans in such a manner as to trigger preemption under § 514(a).

In reaching the conclusion that the DRG statute was not preempted, the court stated that it was "unwilling to attribute to Congress and § 514 an intent to frustrate the efforts of a state, under its police power, to regulate health care costs. In particular, we are unwilling to infer from ERISA's prohibition against applying fund assets for the benefit of others a Congressional intent to foreclose health care cost regulation of the kind here challenged." (App. at 31a-32a.)

The NCCMP submits that the court's rationale suffers from two fatal flaws. First, there is nothing to support the proposition that Congress intended to leave states free to regulate state health care at the expense of ERISA plans, under the authority of their traditional state police powers. Second, there is nothing to support the court's view that ERISA leaves states free to compel self-funded plans to divert trust assets to fund the benefits of persons other than plan participants and beneficiaries.

In its obvious desire to support the well-intended social objectives articulated in New Jersey's DRG statute, the

court of appeals completely disregarded the nature of collectively bargained self-funded ERISA plans, confounded the generally applicable costs of doing business with the express use of fund assets to subsidize a particular group of nonparticipants, and impermissibly intruded upon an area reserved exclusively to the legislative powers of Congress. The NCCMP is concerned that unless the ruling is reviewed and reversed, other courts may carve out judicial exceptions to ERISA's preemption clause, not only for state health care financing laws but for other state efforts to promote social goals at the expense of self-funded plans whose resources are limited.

A. The Third Circuit's Ruling is Inimical to ERISA Because it Fails to Appreciate the Nature of Multiemployer Plans and Requires the Diversion of Fund Assets to Pay for the Benefits of Nonparticipants on the Grounds that this is a Mere Cost of Doing Business in the State.

Multiemployer employee welfare benefit plans are plans created by the parties to collective bargaining agreements for the purpose of providing health and welfare benefits to workers and their families. In addition, many welfare benefit plans provide sorely needed coverage to retirees.

Most collectively bargained plans are self-funded through the ongoing contributions of several, hundreds, or even thousands of employers in one or more industries involving participants working or living in one, several, or many states. The contributions are pooled for investment to provide benefits to all participants in the plan, and their families. A key feature of multiemployer plans is that participants can move from one contributing employer to another within the plan without losing their benefit rights, making such plans a model for portability.

The parties to collective bargaining agreements negotiate the rate of contributions the employer will agree to pay during the life of the contract, as well as the job classifications to be covered. As Mr. Robert A. Georgine, Chairman of the NCCMP, explained in a letter to the

Speaker of the House,[6] urging a national solution to the health care problem rather than "the current crazy-quilt, state-by-state system that is killing multiemployer health plans":

> Collectively-bargained 'employer' contributions to multi-employer health plans are part of a covered worker's compensation package for his or her labors. Such contributions are in lieu of cash wages. Workers forego a portion of their wages and wage increases to have their employers contribute to multiemployer health plans. Increases in plan costs caused by taxes and other government-imposed charges divert plan assets away from benefits for the covered workers and their families. Increased plan costs mean increases in the rate of contributions, and declining wages, as a greater portion of the workers' compensation package is allocated to health plan contributions instead of wages.
>
> Our plans are already troubled by the uncontrolled inflation in health care costs and cost-shifting, and covered workers are increasingly faced with benefit cutbacks and wage reductions as a result. The economic recession has exacerbated these troubles, as the lack of work causes declines in plan contribution income and increases in benefit usage.

"How," Mr. Georgine asks, "do you explain to a union construction worker that he must divert a portion of his wages to the health care provided to uninsured, nonunion construction workers" when it is precisely this kind of cost-shifting that is impeding the progress of national health care reform while "discourag[ing] the maintenance of employee health plans [and] only serves to broaden the uninsured problem in this nation." *Id.*[7]

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[6] Letter from Robert A. Georgine to the Honorable Thomas S. Foley, Speaker of the House of Representatives, dated May 21, 1993, expressing the NCCMP's views on "ERISA waivers" for state health care financing laws and urging Congress not to include such waivers in the Omnibus Budget Reconciliation Act of 1993. As will be discussed below, the waivers were not granted.

[7] As the NCCMP pointed out in its *amicus* brief in support of a multiemployer plan in *FMC Corp. v. Holliday*, 498 U.S. 52 (1990),

The answer to this question is that ERISA precludes the type of cost-shifting that was implemented by the DRG statute and reflected in the surcharges. First, although the parties to collective bargaining agreements negotiate the amount of money the employer agrees to dedicate to providing health benefits, it is the trustees of self-funded ERISA plans who normally have sole discretion and authority—under the governing trust agreement and applicable benefit plan—to determine the type and range of benefits the plan can and will provide and to establish eligibility requirements on the basis of the plan's financial resources and such actuarial considerations as the number and age of participants and previous claims experience. These are sensitive determinations that frequently require the input of the fund's actuarial consultant.

Moreover, since § 302(c)(5) of the Labor-Management Relations Act of 1947, as amended, 29 U.S.C. § 186 (5)(c) ("LMRA"), prohibits employers from making and employee benefit plans from accepting contributions except pursuant to a detailed written agreement specifying, among other things, the persons on whose behalf the contributions are being made; and since § 404(a)(1) of ERISA, 29 U.S.C. § 1104(a)(1), imposes on trustees a fiduciary obligation to act in the sole and exclusive interest of the plan's participants and beneficiaries, the basic premise of eligibility for benefits in self-funded multiemployer plans is coverage under a collective bargaining agreement. While the trust agreements of some multiemployer funds permit trustees to extend coverage to other classes of persons under participation agreements with the trustees, for example, the employees of the union

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a three-year study prepared by the Services Employees International Union, *Labor and Management: On a Collision Course over Health Care*, while recommending a 'systemic' change in the way health care is provided, stated that the number of strikes over who will pay the rising costs of health care has increased by more than 300% since 1986, and that such work stoppages in 1989 alone cost the United States economy more than $1.1 billion in lost wages and productivity. 17 *Pens. Rep.* (BNA) 375 (Feb. 26, 1990).

or of the fund, nothing in federal employee benefits law authorizes fund trustees to divert trust assets to finance the benefits of individuals who are not covered by written collective bargaining agreements or participation agreements and whom the trustees, in their sole discretion, have not admitted to participation in the fund, such as the uninsured individuals protected by New Jersey's DRG statute.[8] It follows that where trustees have sole discretion to determine questions of eligibility, as typically occurs in self-funded plans, trustees do not act arbitrarily and capriciously by refusing to pay benefits to ineligible individuals. *See Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101 (1989).

Indeed, several provisions of ERISA explicitly prohibit the diversion of trust assets to persons other than participants and beneficiaries of the plan. For example, § 403(c)(1), 29 U.S.C. § 1103(c)(1), provides that the "assets of a plan shall never inure to the benefit of any employer and shall be held for the exclusive purpose of providing benefits to participants in the plan and their beneficiaries." Likewise, § 404(a)(1)(A), 29 U.S.C. § 1104(a)(1)(A), requires the trustees, as fiduciaries, to discharge their duties to the plan "for the exclusive purpose of providing benefits to participants and beneficiaries" while § 404(a)(1)(D), 29 U.S.C. § 1104(a)(1)(D), obligates the trustees to act in accordance with the governing plan documents as long as these documents are consistent with ERISA.

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[8] *See Doyle v. Shortman*, 311 F. Supp. 187 (S.D.N.Y. 1970), still regarded as a leading case for the proposition that employee benefit funds may, without violating § 302(c)(5) of the LMRA, extend coverage to the employees of nonunionized employers who agree to comply with the terms of the trust and who pay the appropriate contributions *if* the trust agreement permits such extensions of coverage, the trustees agree to extend it, and the employer executes an appropriate agreement; *see also Seafood Workers Health Fund Union Trustees v. Seafood Workers Health Fund Management Trustees*, 571 F. Supp. 483 (D. Mass. 1983), indicating that trustees cannot be compelled to accept such employees for participation, absent appropriate contracts.

The Third Circuit's ruling, however, requires fund trustees to violate ERISA's mandates by diverting millions of dollars to pay for the benefits of nonparticipants. Although the Third Circuit stated that it was "not troubled" by this aspect of the cost-shifting structure of the DRG statute, the NCCMP submits that the court of appeals failed to appreciate the requirements of ERISA and the LMRA, mischaracterized the surcharges as the mere cost of doing business in New Jersey, and ruled in a manner that is totally inconsistent with this Court's decision in *Local 144 Nursing Home Pension Fund, et al. v. Demisay*, —— U.S. ——, 113 S. Ct. 2252 (1993).

The issue in *Demisay* was whether a federal district court could issue an injunction under § 302(e) of the LMRA, and thereby compel the trustees of a multiemployer trust to transfer assets from that fund to a new multiemployer trust fund established by employers who had broken away from the first fund. The issue arose because the union, in negotiating a change of funds, was concerned that covered employees would not lose benefits as a result of the change. To address that concern, the affected employers made certain guarantees in their collective bargaining agreements, which created some peculiar liabilities for the new funds. To finance these liabilities, the trustees of the new funds brought an action to compel the old funds to transfer that portion of their reserves that were attributable to the employers' past contributions for the employees to be covered by the new funds, claiming that the failure to transfer these amounts created a structural defect which violated § 302(c)(5) and was remediable under § 302(e).

The gravamen of the employers' argument was that § 302(c)(5) forbids the use of an employer's contributions to provide benefits to anyone other than that employer's employees. Although the majority decided the case on the broad grounds that federal district courts do not have authority under § 302(e) to issue injunctions to compel trustees to administer employee benefit trusts in accordance with § 302(c)(5), and that breaches of trust

are remediable solely under ERISA, three members of the Court, in a strong concurring opinion that is relevant to the case at bar, decided the issue on narrower grounds, concluding that the old fund's failure to transfer assets did not violate § 302(c)(5), because this provision of the LMRA contemplates that employer contributions will be used both for the sole and exclusive benefit of the contributing employer's employees *and* the employees of similarly situated employers making contributions to the fund:

> That some portion of respondent's contributions will go to benefit the employees of other contributors is, of course, in the nature of a multiemployer plan. Such plans operate precisely as suggested by the language of § 302(c)(5), by pooling employer contributions for the joint benefit of all participating employees. Segregation of funds by an employer is neither feasible nor contemplated.

With regard to collectively bargained multiemployer plans, ERISA incorporates the requirements of § 302(c)(5). If, consistent with federal law, trustees cannot be compelled to upset the pool by diverting fund assets to subsidize the benefits of former participants who are subsequently covered by a new plan, it is clear that trustees should not be compelled to upset the pool by diverting fund assets to subsidize the benefits of individuals who were never participants in the plan. The Third Circuit's ruling fails to take proper account of the manner in which multiemployer pooled trusts are founded and funded.

Moreover, while basic DRG rates, which include indirect costs such as research and hospital maintenance, can arguably be regarded as a generally applicable cost of doing business, surcharges which have been added on to the basic DRGs for the express purpose of subsidizing hospital care for nonparticipants are a qualitatively different cost. At a minimum, these surcharges "relate to" employee benefit plans because they compel trustees to act in violation of the plan documents. Put differently, participants may be said to receive the benefit of indirect

costs such as hospital maintenance; however, they obtain no benefits from the surcharges, which also put the plans at risk.

The NCCMP is concerned that unless this Court reviews the Third Circuit's ruling, and clarifies both the nature of pooled trusts and the parameters of the "cost of doing business" exception to preemption, if there is one, other courts may uphold state laws having an inordinate impact on multiemployer plans on the grounds that the economic impact—however intrusive and oppressive—is merely a cost of doing business in the state and therefore, does not "relate to" employee benefit plans in such a manner as to trigger preemption.

B. The Third Circuit has Intruded Impermissibly Upon an Area Reserved Exclusively to Congress.

As noted above, the Third Circuit has, by judicial fiat, carved out an exception from preemption for state health care financing statutes on the assumption that Congress did not intend to prevent states from regulating health care costs under their traditional police powers even if such regulation results in the diversion of fund assets to pay for the benefits of nonparticipants. The NCCMP submits that the court's assumption is incorrect. The NCCMP is therefore concerned that the ruling, unless reviewed and reversed may prompt other courts of appeals to carve out similar exemptions, not only for state health care financing laws but also for other laws promoting important state objectives,[9] in derogation of Congress's de-

[9] It may be recalled that prior to this Court's decision in *FMC Corp. v. Holliday, supra,* the Courts of Appeals for the Third and Sixth Circuits had carved out an exemption from preemption for state no-fault insurance statutes, opining that such statutes should be "saved" because they promoted important state interests without impermissibly intruding on "core" ERISA concerns. *FMC Corp. v. Holliday,* 885 F.2d 79 (3d Cir. 1989); *Northern Group Services, Inc. v. Auto Owners Ins. Co.,* 833 F.2d 85 (6th Cir. 1987). The NCCMP filed an *amicus* brief in *Holliday* because it feared that the "core ERISA concern" standard of preemption would erode the "deemer" clause and "save" a whole variety of state statutes and common law rules regulating insurance, banking, and

termination that employee benefit plans should be regulated exclusively by federal law.

The NCCMP submits that the plain language of § 514, 29 U.S.C. § 1144, does not support the Third Circuit's assumption. First, § 514(a) clearly states that ERISA supersedes any and all state laws relating to employee benefit plans (with limited exemptions not relevant here). Nowhere in § 514 is there a legislative exemption for generally applicable state laws that also relate to employee benefit plans, no less for generally applicable state laws regulating health care. Rather, § 514(b)(2)(A) "saves" from preemption only those state laws that regulate insurance, banking, and securities (except as applied to self-insured plans which—under § 514(b)(2)(B)—are deemed not to be engaged in the business of insurance, banking, or securities for purposes of those laws), while § 514(b)(4) exempts generally applicable *criminal* laws from the reach of § 514(a).

Where Congress wished to create an exemption for state health care financing laws, it did so expressly in the statute. Thus, § 514(b)(5)(A) contains an express exemption for the Hawaii Prepaid Health Care Act while §§ 514(b)(5)(B) and (C) contain equally express limitations on the exemption.

That state health care financing laws relating to employee benefit plans are clearly preempted by ERISA unless and until *Congress* decides to exempt them is clearly evidenced by a bill which Senator Durenberger introduced

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securities since courts would be likely to differ on what they perceived as "core ERISA concerns." The NCCMP has even greater concerns with regard to the Third Circuit's ruling in *United Wire* because, in contrast to *Holliday*, which involved the scope of the "deemer" clause, the court's interpretation of § 514(a) does not even leave open the possibility of distinguishing between self-funded and insured plans to secure the greater protection which this Court has afforded self-funded plans in *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724 (1984) and in *Holliday*, 498 U.S. 52 (1990).

in September 1992.[10] That bill, entitled "State Health Care Financing Equity Act of 1992," [11] was intended to waive certain preemption requirements of ERISA by adding two paragraphs (9 and 10) to § 514(b) to exempt from the reach of § 514(a) any qualified state health financing program that imposes a tax, premium, or surcharge on health plans doing business in the state (including self-funded plans) or requires such plans to participate in a risk pool for the medically uninsurable.

The proposed bill expressly provided that states would not be prohibited from setting hospital rates prospectively under a DRG methodology which could include charges for uncompensated care, as well as for adjustments necessitated by Sections XVIII and XIX of the Social Security Act. However, states would have to apply for an ERISA waiver, and federal review and oversight was intended to be both comprehensive and pervasive, *inter alia,* to assure that the state law would be capable of fulfilling its goals and would also be nondiscriminatory.

To date, this bill has not been passed, perhaps in anticipation of national health care reform. However, four states (Hawaii, New York, Maryland, and Minnesota) have more recently applied for individual waivers from ERISA preemption—as part of the proposed Omnibus Budget Reconciliation Act of 1993 ("OBRA")—to allow them to regulate hospital rates and to permit them to recover the cost of providing indigent care by imposing surcharges and by increasing costs for health plan participants (including participants in self-funded plans). As enacted on August 4, 1993, OBRA contains no provision granting any state an exemption from ERISA preemption. P.L. 103-66 (1993).

In light of the above, it is clear that if exemptions from ERISA preemption are to be made for state health care

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[10] S. 3223, 138 Cong. Rec. S13267-02 (introduced on September 10, 1992).

[11] The bill was divided into two major sections, captioned "Waiver of ERISA Preemption for State Universal Health Plans" and "State Provider Taxes and Prospective Payment Systems."

financing statutes, the exemptions must be made by Congress and not by the courts, which are neither equipped nor authorized to solicit, process, or debate the type of broad-based information that must necessarily be considered and balanced in the course of amending a complex federal statute of great national scope, such as ERISA.

Prompt clarification of this preemption issue is essential. First, multiemployer plans have already paid millions of dollars to New Jersey hospitals under protest or have escrowed the surcharge amounts pending a decision whether the DRG statute is preempted. Second, 26 states have established risk pools to insure the medically uninsurable by assessing taxes and premiums on insurers, and other states are developing similar programs to provide broad-based access to health care to be financed by similar taxes or premiums. In addition, 22 states currently impose taxes on hospitals, doctors, and other providers to finance uncompensated health care.[12] Unless the Third Circuit's ruling is reviewed and reversed, even those states which have not yet attempted to reach the assets of self-funded plans, as have New Jersey, New York, and several other states, may be encouraged to do so on the grounds that such premiums are part of the costs of doing business in the state.

The NCCMP has vigorously opposed Congressional efforts to enact ERISA waivers for individual states because of its fundamental belief that "the health care crisis is a national problem that requires a uniform, federal solution, not fifty different conflicting solutions." [13] For the same reasons, the NCCMP even more vigorously opposes judicial efforts to carve out exemptions from preemption for such laws which threaten to perpetuate and increase the current crazy-quilt, state-by-state system of

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[12] 138 Cong. Rec. S13267-02, *S13268. The above information is contained in a "factsheet" supporting the proposed State Health Care Financing Equity Act.

[13] Letter from Robert A. Georgine to the Honorable Thomas S. Foley, dated May 21, 1993.

unfair cost-shifting that is jeopardizing multiemployer plans.

II. THE THIRD CIRCUIT'S DECISION IS INCONSISTENT WITH THIS COURT'S PREVIOUS DECISIONS AND CLOUDS THE CLEAR STANDARDS DEVELOPED BY THIS COURT.

Petitioners have clearly articulated the standards for preemption which this Court has enunciated in its prior decisions, and have shown how the Third Circuit has departed from those decisions, largely in reliance on an outdated decision of the Second Circuit, which even a New York court declined to follow in ruling that the surcharges imposed by New York's DRG statute are preempted by ERISA.[14] The NCCMP agrees with Petitioners' arguments, and will not repeat them here.[15]

However, the NCCMP would like to reiterate its concern that unless the Third Circuit's opinion is reviewed and reversed, federal courts will be encouraged both to depart from this Court's common sense, broad reading of § 514(a) and to carve out judicial exemptions from preemption for any one of the following reasons: the state law does not "purport to relate to" employee benefit plans; the state law is generally applicable and falls within traditional police powers; or the state law, despite its inordinate economic impact on employee benefit plans, has too remote or tenuous a connection with the plans to trigger preemption. Most importantly, the NCCMP is concerned that unless the Third Circuit's ruling is reviewed, the economic burdens imposed on plans by state laws will no longer figure in the ERISA preemption calculus on the grounds that such burdens are a mere cost of doing business in the state.

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[14] *Rebaldo v. Cuomo*, 749 F.2d 133 (2d Cir. 1984), *cert. denied*, 472 U.S. 1008 (1985); *Travelers Ins. Co. v. Cuomo*, 813 F. Supp. 996 (S.D.N.Y. 1993), appeal pending.

[15] The NCCMP also agrees with the district court's analysis in the case below, 793 F. Supp. 524 (D.N.J. 1992), as well as with Judge Nygaard's dissenting opinion on appeal, App. 32a-44a.

In the case at bar, the DRG statute clearly "relates to" employee benefit plans because: the statute was premised on the existence of ERISA plans as deep pockets; specifically referred to ERISA plans; operated through a cost-shifting mechanism designed to drain ERISA plans of assets for the purpose of funding benefits for nonparticipants, in violation of plan documents and trustees' fiduciary obligations to participants and beneficiaries; forced plans to restructure or eliminate benefits to accommodate the drain on plan assets; and increased the costs and burdens of plan administration. Moreover, DRG statutes, such as New Jersey's, could well cause plans to change their design by shifting from self-funded to insured status, if only to be able to benefit from the payor differentials afforded high volume insurers such as Blue Cross.

This Court has repeatedly pointed out that "ERISA preempts any state law that refers to or has a connection with covered benefit plans (and that does not fall within a § 514(b) exception) even if the law is not specifically designed to affect such plans, or the effect is only indirect." *District of Columbia v. Greater Washington Board of Trade*, 506 U.S. ——, 121 L.Ed.2d 513, 520 (1992) (citations omitted). Moreover, Congress clearly knows how to draft a § 514(b) exemption for state health care laws if it so desires, and did so for Hawaii's Prepaid Health Care Act. There is nothing in the structure of § 514 or in this Court's previous interpretations of ERISA's preemption provision to justify courts in carving out judicial exemptions from preemption merely because the state law may serve an important social goal.

In sum, the Third Circuit's ruling is inconsistent with this Court's previous precedents, casts a shadow on the standards enunciated by this Court, and threatens to cause great harm to self-funded multiemployer plans.

CONCLUSION

For the reasons stated above, the Court should grant the Petition for Certiorari and review the decision of the court below.

Respectfully submitted,

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